

**KIMBROUGH AMBULATORY CARE CENTER  
AUTHORIZATION TO RELEASE PRESCRIPTION(S)**

I, \_\_\_\_\_, \_\_\_\_\_,  
( Print full name) (Sponsor's social security number)

authorize \_\_\_\_\_ as my representative to  
(Print full name)

pick up prescriptions and prescription refills on my behalf.

Signature

Date

**IMPORTANT**

**In accordance with The Army Surgeon General's policy letter, Supplemental Guidance 98-0020P:**

- 1. The person you designate above to represent you must provide a photocopy of your military identification (ID) card, front and back.**
- 2. Your representative must possess a valid military ID card or other valid photo ID to verify his or her identity.**
- 3. This authorization is valid for one year from the date signed.**

**MEDDAC (Ft Meade) Form 751**

1 Oct 02